



# STATE OF IOWA

CHESTER J. CULVER  
GOVERNOR

PATTY JUDGE  
LT. GOVERNOR

IOWA DENTAL BOARD  
CONSTANCE L. PRICE, EXECUTIVE DIRECTOR

## INSTRUCTIONS FOR COMPLETING APPLICATION FOR TEMPORARY IOWA PERMIT

Enclosed is an application for a temporary permit to practice dentistry in Iowa. When completing this application, please be advised of the following.

- For specific permit requirements, please refer to the Board's rules at Iowa Administrative Code 650—13.3(153).
- A temporary permit is designed to fulfill an urgent need in the state of Iowa, to serve an educational purpose, or to provide volunteer services. A temporary permit is NOT intended as a way to practice before a permanent license is granted or as a means to practice because the applicant does not fulfill the requirements for permanent licensure. A temporary permit may be granted on a case-by-case basis.
- A temporary permit to provide volunteer services is intended for dentists or dental hygienists who will provide volunteer services at a free or nonprofit dental clinic and who will not receive compensation for dental services provided. A temporary permit for volunteer services is valid only at the location specified on the permit, which shall be a free clinic or a dental clinic for a nonprofit organization, as described under Section 501(c)(3) of the Internal Revenue Code.
- The issuance of a temporary permit has NO long-term implications for licensure. If the need changes or if a permit holder wishes to continue in short-term assignments in other Iowa locations, the permit holder is expected to seek permanent licensure.
- The board may issue a temporary permit authorizing the permit holder to practice at a specific location or locations in Iowa for a specified period up to three months. Following expiration of the permit, a permit holder shall be required to obtain a new temporary permit or a permanent license in order to practice dentistry or dental hygiene in Iowa.
- Dentists practicing in the state of Iowa cannot administer deep sedation/general anesthesia or conscious sedation in the practice of dentistry unless a separate permit has been obtained from the Iowa Board of Dental Examiners. The application form for a permit is available on the Board website.
- All or part of the information provided on the application form may be considered a public record under Iowa Code chapter 22 and Iowa Administrative Code 650—Chapter 6. Information on misconduct, criminal history, and examination results is not subject to disclosure.
- Applications are issued administratively following review of a completed application and all required credentials, unless the application warrants referral to the license and examination committee, the full Board, or unless a personal appearance is required.
- The application fee is non-refundable.
- Applications are valid for only six months from the date of receipt. If a permit has not been issued within six months, a new application will have to be submitted.
- **Failure to answer all questions completely or accurately, and/or omission or falsification of material facts may be cause for denial of your application or disciplinary action.**

To assist you in completing the application, please utilize the following checklist and be sure that you have responded to each item.

☐ Type or legibly print the application.

☐ Complete each question on the application. If not applicable, answer N/A.

☐ On page 1, indicate the specific location, dates needed, and reason/need for the temporary permit.

- ☐ Attach a practice reference for each practice location in the last three years. Attach at least one practice reference per location.
- ☐ For each "Yes" answer to questions 1 through 22 in section 8, you must provide a separate, signed statement giving full details, including date(s), location(s), action(s), organization(s) or parties involved, and specific reason(s).
- ☐ Attach a photograph to the application that is suitable for positive identification.
- ☐ The application must be notarized.
- ☐ Include the original or a notarized copy of your National Board card reflecting your scores.
- ☐ Include a copy of your scores from any national, regional, or state licensing examination. If you have taken a clinical examination more than once, you must submit scores from each examination.
- ☐ Enclose a notarized copy of your diploma from dental school.
- ☐ Complete and enclose the form "Authorization for Release of Personal Information."
- ☐ Forward the form "Certificate of Dental Education" to your dental school and request the completed form be submitted directly to the Board office.
- ☐ Include a notarized copy of your marriage certificate or divorce decree if the name on your application is different than the name on your diploma or other documents.
- ☐ Include evidence of possessing a valid, current certificate in a nationally recognized course in cardiopulmonary resuscitation (such as a photocopy of the front and back of your current CPR card).
- ☐ Request a license certification from each state in which you have ever been licensed. Mail the enclosed form to each state and request that the certification be forwarded directly to the Board office. Please note that some states require a fee to process the enclosed form.
- ☐ Submit a letter to the Board stating: a) the reason why you need a temporary permit and your practice plans; b) whether or not you dispense drugs as part of your practice; c) whether or not your practice includes the administration of general anesthesia or conscious sedation; d) that you understand that a temporary permit is not meant as a way to practice before a permanent license is granted or as a means to practice because the applicant does not fulfill the requirements for permanent licensure; and e) that you understand that if the permit is issued it is valid for no more than three months. If you are seeking a temporary permit for volunteer services, your letter should also state that you understand that you can only practice at a free dental clinic or dental clinic for a nonprofit organization and that you shall not receive compensation for providing dental services.
- ☐ Include a letter from the person or organization seeking your services that establishes the need for the temporary permit, the dates your services are needed, and the location or locations where those services will be delivered. For volunteer services, the letter must also indicate whether the clinic is a free clinic or nonprofit organization, and whether the applicant will receive compensation for services delivered.
- ☐ Enclose the non-refundable application fee made payable to Iowa Board of Dental Examiners. The fee for a temporary permit for an urgent need or to serve an educational purpose is \$100. The fee for a temporary permit to provide volunteer services is \$25.

# APPLICATION FOR TEMPORARY IOWA PERMIT

## IOWA DENTAL BOARD

400 S.W. 8<sup>th</sup> Street, Suite D, Des Moines, Iowa 50309-4687

Ph. (515) 281-5157 <http://www.dentalboard.iowa.gov>



Please read the accompanying instructions prior to completing this application.

### 1. IDENTIFYING INFORMATION

Full Legal Name: (Last, First, Middle, Suffix)			
Other Names Used: (e.g. Maiden)			
Home Address:			Telephone:
City:	County:	State:	Zip:
Work Address:			Telephone:
City:	County:	State:	Zip:
Home Fax:	Home E-mail:	Work Fax:	Work E-mail:
Social Security Number:	<b>Privacy Act Notice:</b> Disclosure of your Social Security Number on this license application is required by 42 U.S.C. § 666(a)(13), Iowa Code §§ 272J.8(1) and 261.126(1), and Iowa Code § 272D.8(1). The number will be used in connection with the collection of child support obligations, college student loan obligations, and debts owed to the state of Iowa, and as an internal means to accurately identify licensees, and may also be shared with taxing authorities as allowed by law including Iowa Code § 421.18.		
Height:	Weight:	Hair Color:	Eye Color:
Identifying Marks:		U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, Visa Type or Alien Registration Number:
Date of Birth:	City of Birth:	State of Birth:	Country of Birth:
Father's Full Name:		Mother's Full Name:	
Full Name & Address of Nearest Relative Not Living With You:			

### 2. BASIS FOR APPLICATION

<b>National Board Examination</b> (Attach original or a notarized copy of National Board card reflecting scores.)	<input type="checkbox"/> Passed	Dates:
<b>Examinations: List all National, Regional, or State Licensure Examinations Taken</b> _____	<input type="checkbox"/> Passed	Dates:
<b>Temporary Permit Practice Location:</b> _____	<b>Dates</b> From:	To:
<b>Reason/Need for Temporary Permit:</b> _____ _____ _____		

Office Use	Lic. #	Diploma	Fee	Cert. Ed
	Book# pg.	Nat'l Bd	Cert. Lic	Ref
	Date issued	Date approved	CRDTS	Juris
	Marriage Cert.	CPR	Fingerprints	

Name of Applicant \_\_\_\_\_

### 3. PRELIMINARY EDUCATION

Name of High School:	City, State:	From (Mo, Yr):	To (Mo, Yr):
Name of College:	City, State:	From (Mo, Yr):	To (Mo, Yr):
Name of College:	City, State:	From (Mo, Yr):	To (Mo, Yr):

### 4. DENTAL/DENTAL HYGIENE EDUCATION

Institution	City, State, Country	From (Mo, Yr):	To (Mo, Yr):
Year (1)			
Year (2)			
Year (3)			
Year (4)			
Degree Received:	Date of Degree:		

### 5. POST-GRADUATE TRAINING

Institution:	Specialty:	From (Mo, Yr):	To (Mo, Yr):
Address:	City:	State/Province:	

### 6. CHRONOLOGY OF ACTIVITIES

Provide a chronological listing of all dental and non-dental activities from the date of your graduation from dental/dental hygiene school to the present date, with no more than a three (3) month gap in time. Include months, years, location (city & state), and type of practice. Attach additional sheets of paper, if necessary, labeled with your name and signed by you. Attach a practice reference for each practice location in the last three (3) years.

Activity & Location	From (Mo, Yr):	To (Mo, Yr):

### 7. LICENSE INFORMATION

List all state/countries in which you are or have ever been licensed.				
State/Country	License No.	Date Issued	License Type (e.g. Resident, Faculty, Permanent)	How Obtained (e.g. Credentials, Exam)

**DEFINITIONS FOR SECTION 8. Important! Read these definitions before completing the following questions.**

**“Ability to practice dentistry with reasonable skill and safety”** means ALL of the following:

1. The cognitive capacity to make appropriate clinical diagnosis, exercise reasoned clinical judgments, and to learn and keep abreast of clinical developments;
2. The ability to communicate clinical judgments and information to patients and other health care providers; and
3. The capability to perform clinical tasks such as dental examinations and dental surgical procedures.

**“Medical condition”** means any physiological, mental, or psychological condition, impairment, or disorder, including drug addiction and alcoholism.

**“Chemical substances”** means alcohol, legal and illegal drugs, or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber’s direction, as well as those used illegally.

**“Currently”** does not mean on the day of, or even in weeks or months preceding the completion of this application. Rather, it means recently enough so that the use of chemical substances or medical conditions may have an ongoing impact on the ability to function and practice, or has adversely affected the ability to function and practice within the past two (2) years.

**“Improper use of drugs or other chemical substances”** means ANY of the following:

1. The use of any controlled drug, legend drug, or other chemical substance for any purpose other than as directed by a licensed health care practitioner; and
2. The use of any substance, including but not limited to, petroleum products, adhesive products, nitrous oxide, and other chemical substances for mood enhancement.

**“Illegal use of drugs or other chemical substances”** means the manufacture, possession, distribution, or use of any drug or chemical substance prohibited by law.

**SECTION 8.** In answering each of the following questions, please check the appropriate box next to each question. **FOR EACH “YES” ANSWER TO QUESTIONS 1 THROUGH 22, YOU MUST PROVIDE A SEPARATE, SIGNED STATEMENT GIVING FULL DETAILS, INCLUDING DATE(S), LOCATION(S), ACTION(S), ORGANIZATION(S) OR PARTIES INVOLVED, AND SPECIFIC REASON(S).**

- | <b>YES</b>               | <b>NO</b>                |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Do you currently have a medical condition that in any way impairs or limits your ability to practice dentistry with reasonable skill and safety?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Are you currently engaged in the illegal or improper use of drugs or other chemical substances?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Do you currently use alcohol, drugs, or other chemical substances that would in any way impair or limit your ability to practice dentistry with reasonable skill and safety?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. If YES to any of the above, are you receiving ongoing treatment or participating in a monitoring program that reduces or eliminates the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances?                     |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. If YES to any of the above, does your field of practice, the setting, or the manner in which you have chosen to practice dentistry, reduce or eliminate the limitations or impairments caused by either your medical condition or use of alcohol, drugs, or other chemical substances? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Except for minor speeding or parking offenses, have you ever been arrested, charged, convicted, found guilty of, or entered a plea of guilty or no contest to a felony or misdemeanor crime or offense, including actions that resulted in a deferred or expunged judgment?            |
| <input type="checkbox"/> | <input type="checkbox"/> | 7. Have you ever been terminated or requested to withdraw from any dental school or training program?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 8. Have you ever been requested to repeat a portion of any professional training program/school?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 9. Have you ever received a warning, reprimand, or been placed on probation during a professional training program/school?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 10. Have you ever been denied a license to practice dentistry?  |
| <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever voluntarily surrendered a license issued to you by any professional licensing agency?   |
| <input type="checkbox"/> | <input type="checkbox"/> | 11a. If yes, was a license disciplinary action pending against you, or were you under investigation by a licensing agency at that time the voluntary surrender of license was tendered?   |

Name of Applicant \_\_\_\_\_

**YES NO**

- ☐ ☐ 12. Have you ever been denied a Drug Enforcement Administration (DEA) or state controlled substance registration certificate?
- ☐ ☐ 13. Have you ever surrendered your state or federal controlled substance registration or had it restricted in any way?
- ☐ ☐ 14. Aside from ordinary initial requirements of proctorship, have your clinical activities ever been limited, suspended, revoked, not renewed, voluntarily relinquished, or subject to other disciplinary or probationary conditions?
- ☐ ☐ 15. Have you ever been terminated, sanctioned, penalized, had to repay monies to, or been denied provider participation in any state Medicaid, federal Medicare, or other publicly funded health care program?
- ☐ ☐ 16. Are any malpractice claims or complaints in process/pending against you?
- ☐ ☐ 17. Have any settlement agreements been rendered or any judgments entered against you resulting from your practice of dentistry?
- ☐ ☐ 18. Are charges or an investigation currently pending relative to your dental license in any other state?
- ☐ ☐ 19. Has any jurisdiction of the United States or other nation ever limited, restricted, warned, censured, placed on probation, suspended, or revoked a license you held?
- ☐ ☐ 20. Have you ever been notified of any charges filed against you by a licensing or disciplinary agency of any jurisdiction of the U.S. or other nation?
- ☐ ☐ 21. Do you have professional liability suits in process or pending?
- ☐ ☐ 22. Have any judgments or settlements been paid on your behalf as a result of a professional liability case(s)?
- ☐ ☐ 23. Do you understand that if a license is granted by this board, it will be based in part on the truth of the statements contained herein, which, if false, may subject you to criminal prosecution and revocation of the license?

## 9. AFFIDAVIT OF APPLICANT

STATE OF \_\_\_\_\_ COUNTY OF \_\_\_\_\_

I, \_\_\_\_\_, hereby declare under penalty of perjury that I am the person described and identified in this application and that the attached photograph is a true likeness of myself. I also declare that I am the lawful holder of the enclosed diploma, which was procured in the regular course of instruction and examination without fraud or misrepresentation.

I further state that I have read the statutes and rules pertaining to the practice of dentistry as prescribed in Iowa Code chapters 147, 153, and 272C and 650 Iowa Administrative Code. If a permit/license to practice dentistry is issued to me, I understand that if I violate any laws or rules, my license may be revoked as provided by law.

I declare, under penalty of perjury, that my answers and all statements made by me on this application and accompanying attachments are true and correct. Should I furnish any false information, or have substantial omission, I hereby agree that such act shall constitute cause for denial, suspension, or revocation of my license. I also declare under penalty of perjury that if I did not personally complete the foregoing application that I have fully read and confirmed each question and accompanying answer, and take full responsibility for all answers contained in this application.

I hereby agree to abide by the laws and rules pertaining to the practice of dentistry in the state of Iowa.

Signature of Applicant \_\_\_\_\_

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

Signature of Notary Public \_\_\_\_\_

**ATTACH  
CURRENT  
PHOTOGRAPH  
HERE**

NOTARY SEAL

## AUTHORIZATION TO RELEASE INFORMATION

I, \_\_\_\_\_, do hereby authorize a disclosure of records concerning myself to the Iowa Dental Board (IDB). This release includes records of a public, private or confidential nature.

I acknowledge that the information released to the IDB may include material that is protected by federal and/or state laws applicable to substance abuse and mental health information. If applicable, I specifically authorize the release of confidential information to and from the IDB relating to substance abuse or dependence and/or mental health.

I further agree that the IDB may receive confidential information and records, including but not limited to the following records:

- Medical records
- Education records
- Personnel or employment records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Residency or fellowship training records, including records of any remedial, probationary, disciplinary, or any other adverse information contained in those records.
- Any information the IDB deems reasonably necessary for the purposes set forth in this release.

Release of Liability. I do hereby irrevocably and unconditionally release, covenant not to sue, and forever discharge any person or entity, including but not limited to any dental school, residency or fellowship training program, hospital, health care provider, health care facility, licensing board, impaired practitioner program, agency, or organization, which releases information to the IDB pursuant to this release from any liability, claim, or cause of action arising out of the release of such information. I further irrevocably and unconditionally release, covenant not to sue, and forever discharge the IDB, the State of Iowa, and its employees and agents from any liability, claim, or cause of action arising out of the collection or release of information pursuant to this release.

A photocopy of this release form will be valid as an original thereof, even though the photocopy does not contain an original writing of my signature.

This authorization is effective through the completion of the licensure process. I understand I have the right to revoke this authorization in writing, except to the extent that the IDB has already taken action in reliance upon this consent.

**I have read and fully understand the contents of this "Authorization to Release Information."**

\_\_\_\_\_  
**Signature of Dentist**

\_\_\_\_\_  
**Date**

### PROHIBITION ON REDISCLOSURE

This form does not authorize redisclosure of medical information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for alcohol/drug abuse records or by state law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 228) prohibit further disclosure without the specific written consent of the patient except as provided in IAC 12.16(6)"b"2, or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is not sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.

## CERTIFICATION OF EDUCATION

As part of the license application process, the Iowa Dental Board requires that the school at which the applicant received her/his dental or dental hygiene education complete this form. The completed form must be mailed directly from the school to the **IOWA DENTAL BOARD**. Any processing fees are the applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

**Print Name** \_\_\_\_\_ **SS#** \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

\*\*\*\*\*  
This portion of the form should be completed by the school.

**IT IS HEREBY CERTIFIED THAT** \_\_\_\_\_  
(Name of Applicant)

**RECEIVED DENTAL/DENTAL HYGIENE EDUCATION AT** \_\_\_\_\_  
(Circle One) (Name of School)

**LOCATED AT** \_\_\_\_\_  
(Full Address of School)

**FROM** \_\_\_\_\_ **To** \_\_\_\_\_  
(Month/Year) (Month/Year)

**GRANTED A DIPLOMA WITH THE DEGREE OF** \_\_\_\_\_

**DATE DIPLOMA RECEIVED** \_\_\_\_\_  
(Month/Year)

**Was the school accredited by the Commission on Dental Accreditation of the American Dental Association at the time the applicant graduated? Yes** \_\_\_\_\_ **No** \_\_\_\_\_

**President, Dean, Secretary, or Registrar:**

**Print Name** \_\_\_\_\_ **Title** \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Phone #** \_\_\_\_\_ **Fax #** \_\_\_\_\_

SCHOOL SEAL

Return Completed Form to:  
IOWA DENTAL BOARD  
400 S.W. 8th St, Suite D  
Des Moines, IA 50309-4687  
Phone (515) 281-5157

## CERTIFICATION OF LICENSURE

As part of the license application process, the Iowa Dental Board requires that this form be completed by every board that has ever issued any license to the applicant, even if the license is not current. The completed form must be mailed directly from the state licensing board to the **IOWA DENTAL BOARD**. Any processing fees are the applicant's responsibility. The applicant's signature authorizes release of information, favorable or otherwise, directly to the Board.

**Print Name** \_\_\_\_\_ **License #** \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

\*\*\*\*\*

This portion of the form should be completed by the state licensing board.

**IT IS HEREBY CERTIFIED THAT** \_\_\_\_\_  
(Name of Applicant)

**WAS GRANTED LICENSE NUMBER** \_\_\_\_\_ **DATE ISSUED** \_\_\_\_\_

**TO PRACTICE** \_\_\_\_\_ **IN THE STATE OF** \_\_\_\_\_

**DATE LICENSE EXPIRES** \_\_\_\_\_ **LICENSE STATUS** \_\_\_\_\_

**BASIS FOR LICENSURE:**

- ☐ **NATIONAL BOARD EXAM**  
☐ **ENDORSEMENT/RECIPROCITY**  
☐ **STATE BOARD PREPARED WRITTEN AND/OR PRACTICAL EXAM**  
☐ **REGIONAL CLINICAL EXAM, NAME OF TESTING AGENCY** \_\_\_\_\_

☐ **Scores are recorded as follows:**

SUBJECT	PERCENT	SUBJECT	PERCENT
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

☐ **Scores are no longer available, however, I certify that it is apparent the applicant received a score sufficient to meet the licensure requirements of this state at that time; and these requirements were substantially equivalent to the requirements for licensure in Iowa.**

☐ **YES** ☐ **No** **Disciplinary action ever been initiated, pending, or taken?**

**Print Name** \_\_\_\_\_ **Title** \_\_\_\_\_

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Phone #** \_\_\_\_\_ **Fax #** \_\_\_\_\_

Return completed form to: IOWA DENTAL BOARD  
400 S.W. 8th St, Suite D  
Des Moines, IA 50309-4687  
Phone (515) 281-5157

STATE OR BOARD SEAL